Junaluska Family Dentistry

HIPAA FORM

Name of Patient _____ Date of Birth_____

JUNALUSKA FAMILY DENTISTRY is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	**Check type of information that can be given to person/ entity on the left in the same section.**
☐ Voice mail	☐ Appointment reminders ☐ Financial
☐ Other person(s) with permission to receive information about patient listed above (provide name & phone number)	☐ Appointment reminders ☐ Financial ☐ Treatment
☐ Email communication (Provide email address) _____ *For email communication to occur, please accept the disclosure below.	☐ Appointment reminders ☐ Financial ☐ Treatment
☐ Text communication (provide phone number) _____ *For text communication to occur, please accept the disclosure below.	☐ Appointment reminders ☐ OTHER_____

☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

☐ Emergency Contact Name_____ Phone Number_____	Photo taken (Example: pre/post procedure) ☐ May be posted in office ☐ May be posted on website and/or social media page

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

Signature of patient or personal representative_____ Date_____

Junaluska Family Dentistry

OFFICE AND FINANCIAL POLICIES

It is required that you read and sign this form before any treatment.

- No one is permitted in treatment room except patient.
- Even though we have done our best to provide a through examination and treatment recommendation, additional conditions may be discovered at subsequent visits either with the Doctor or Hygienist as debris are removed or other services are performed.
- In order to avoid interruption in our work with patients, or front desk staff has been given the responsibility for making appointments and the collections of fees and accounts. Please consult them concerning these matters.

Financial Policy: Should you need financing, please request information prior to any appointment for treatment. A definite arrangement for payment of fees must be made prior to any appointment for treatment. Payment is due at time of service.

Broken Appointment Policy: It is our policy to allow our patients to cancel or reschedule any appointment with 48 hours notice**. Any patient who "no shows" or cancels without 48 hours notice will be charged a non-refundable fee.** This includes your first visit here.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

In regard to Privacy, I understand that Junaluska Family Dentistry staff may use or disclose personal health information for the purposes of carrying out treatment, specialty referrals, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand I have the right to restrict how my personal health information is used and disclosed if I notify the practice in writing. I also understand that any request will be considered on a case by case basis, but Dr. Osborne does not have to agree to requests for restrictions.

Signature of patient/responsible party_____ **Date**_____